

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12397

11291 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it on a separate sheet, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Md.		c. LENGTH OF STAY IN 1b 15 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Md.		d. STREET ADDRESS Andrews Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None Andrews Md.				d. STREET ADDRESS Andrews Md.		e. IS RESIDENCE ON A FARM? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John W. Adams		First	Middle	Lost	4. DATE OF DEATH Nov. 30, 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Lakesville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Wesley Adams		14. MOTHER'S MAIDEN NAME Fannie Wroten		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Eva Hughes		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure INTERVAL BETWEEN ONSET AND DEATH 1 mo.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic C-V. Disease		(b)		(c)				
DUE TO		DUE TO		DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 12/2/56						
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 2, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Wesley Church		22d. LOCATION (City, town, or county) Andrews Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.		24a. REC'D BY REGISTRAR John Mace Jr. DATE 12/3/56 24b. REGISTRAR'S SIGNATURE						

REGISTRATION STATE DEPARTMENT OF DEFENSE 10
REGISTRATION STATE DEPARTMENT OF DEFENSE 10

BUREAU V. S.

DEC 10 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

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VS. A15ME(5)
5M 9/55

11292 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G209, 1/7/57, fcy

11268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Dorchester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge, R. F. D. 2</i>		c. LENGTH OF STAY IN lb <i>22 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		d. STREET ADDRESS <i>R.F.D. 2</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Indian Bone Road</i>				e. IS RESIDENCE ON A FARM? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Thomas G. Collins Jr.</i>		First	Middle	Last	4. DATE OF DEATH <i>11 18 1956</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 11, 1931</i>	9. AGE (In years last birthday) <i>22 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	11. KIND OF BUSINESS OR INDUSTRY <i>any labor</i>	12. BIRTHPLACE (State or foreign country) <i>Dorchester, Md.</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Thomas Collins Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Marion Keene</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-28-1119</i>	17. INFORMANT <i>Thomas G. Collins</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intra Cranial injury</i>				INTERVAL BETWEEN ONSET AND DEATH <i>instant</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>822X</i>		(b) <i>Multiple Fracture of skull</i>						
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Driver of car which overturned and threw him out.</i>						
20c. TIME OF INJURY Hour a. m. p. m. <i>11-18 1956</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) <i>Cambridge</i>	(County) <i>Dor</i>	(State) <i>Md.</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mac Jr. M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>11/20/56</i>				
EXAMINER'S NAME (Type) <i>John Mac Jr. M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/22/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Smithville, Md.</i>	22d. LOCATION (City, town, or county) <i>Smithville</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leon W. Henry</i>		ADDRESS <i>Cambridge, Md.</i>		24a. REC'D BY REGISTRAR <i>11/21/56</i>	24b. REGISTRAR'S SIGNATURE <i>John Mac Jr.</i>	DATE		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb 30 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS Glenburn Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenburn Convelescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles		First R.	Middle Creighton	Last None	4. DATE OF DEATH Nov. 3, 1956	Month Nov.	Day 3	Year 1956
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1869	9. AGE (in years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Fishing Creek Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Creighton				14. MOTHER'S MAIDEN NAME Eliza Wallace				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-0744		17. INFORMANT Calvert Creighton		Address East New Market Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile Arteriosclerosis ? (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Intra trochanteric fracture neck l. femur 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell in home						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10/7/1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home Cambridge Co. Md.		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John Mace Jr.		DATE SIGNED 11/5/56						
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR 11/6/56		24b. REGISTRAR'S SIGNATURE John Mace Jr.		

EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
FEB 7 1956
FBI - NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11270

11276 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb 28 Years				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 210 Willis St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				
3. NAME OF DECEASED (Type or print) George		First S.	Middle Dean			
4. DATE OF DEATH Nov. 1 1956	Last 1	Month Nov.	Day 1			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 10, 1857			
8. WIDOWED <input type="checkbox"/>	9. DIVORCED <input type="checkbox"/>	10. AGE (In years last birthday) 99	11. IF UNDER 1 YEAR yrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	11. BIRTHPLACE (State or foreign country) Bishops Head Md.			
13. FATHER'S NAME Not Known		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Virgil G Dean Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic cardio vascular renal disease		INTERVAL BETWEEN ONSET AND DEATH 48 hours				
(b) DUE TO Arteriosclerotic cardio vascular renal disease		10 years				
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. -- 19 p.m. --		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) ---	(County) ---	(State) ---
21. I certify that I attended the deceased from 12-12 , 19 55 , to 11-1-56 , 19 56 , that I last saw the deceased alive on 10-31-56 , 19 56 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Maryland						
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>	DATE SIGNED 11-2-56					
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 3, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge		
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service		24a. REC'D BY REGISTRAR Cambridge		24b. REGISTRAR'S SIGNATURE John MacL.		
VS A15 (4) 15M 9/55		DATE 11-1-56				

WISCONSIN STATE DEPARTMENT OF AGRI-CULTURE - BUREAU OF

CERTIFICATE OF DEATH

BUREAU OF
RECEIVE

NOV 7 1956

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VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12407

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reids Grove		c. LENGTH OF STAY IN 1b 6 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reids Grove			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Clifton Middle Last Fridie		4. DATE OF DEATH 11 - 13 Day 19 56 Year					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Can't say	9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Saw mill		11. BIRTHPLACE (State or foreign country) South Carolina ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. 251-32-3284 17. INFORMANT Roosevelt McCloud Address Reids Grove, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute alcoholism (iso-propyl) 880.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 6 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drank pint of isopropyl alcohol					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11-13 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				DATE SIGNED 11/29/56			
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 16, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Rhodesdale Cemetery		22d. LOCATION (City, town, or county) (State) Rhodesdale, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE 12/7/56 <i>John Mace Jr.</i> 24b. REGISTRAR'S SIGNATURE			

DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 10 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH								11271 Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek, R.D.		c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wallace Creek in Church Creek dist.				d. STREET ADDRESS Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF -DECEASED (Type or print)		First Elmer	Middle McClelland	Lost Hall	4. DATE OF DEATH Nov. 18, 1956	Month Day	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1886	9. AGE (in years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milk delivery driver, self employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Fishing Creek, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME George W. Hall				14. MOTHER'S MAIDEN NAME Susan Tolley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No 220-16-9243		17. INFORMANT Mrs. Clarence Newcomb, Fishing Creek, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH Instant
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran into creek.						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11-18 1956 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway bridge		20f. (City or town) Church Creek Dor.	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Macle Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 11/20/56
EXAMINER'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Hoosier Mem. Churchyard		22d. LOCATION (City, town, or county) (State) Fishing Creek, Maryland.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth K. Showalter</i>								ADDRESS Cambridge, Maryland
								24a. REC'D BY REGISTRAR DATE 11/20/56
								24b. REGISTRAR'S SIGNATURE <i>John Macle Jr.</i>

1951 VEHICLE EVALUATION CERTIFICATE OF DESIGN

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11272
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Dorchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock</i>	
c. LENGTH OF STAY IN 1b <i>All life</i>		d. STREET ADDRESS <i>Broad St</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles W. Hastings</i>		First <i>W.</i>	Middle <i>H.</i>
4. DATE OF DEATH <i>11/1/1956</i>		Lost <i>9/15/1873</i>	Month <i>83</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/15/1873</i>
9. AGE (In years (at birthday) yrs.) <i>83</i>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>1</i> Hours <i>00</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Selling Real Estate</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert R. Hastings</i>		14. MOTHER'S MAIDEN NAME <i>Harriet</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Mrs Daisy M. Hastings</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>571.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>Chronic Myocardial Degeneration & Atrial Fibrillation</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Hurlock, Md.</i>		20f. (City or town) (County) (State) <i>Hurlock, Md.</i>	
21. I certify that I attended the deceased from <i>Oct 31, 1956</i> to <i>Nov. 1, 1956</i> , that I last saw the deceased alive on <i>November 1, 1956</i> , and that death occurred at <i>9:00 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>W.C. Harrison</i> PHYSICIAN'S NAME (Type) <i>W.C. Harrison M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>11/4/56</i>	
22c. NAME OF CEMETERY OR CREAMATORY <i>Washington</i>		22d. LOCATION (City, town, or county) <i>Hurlock, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth M. McNeely, O.J. McNeely</i>		24a. REC'D BY REGISTRAR DATE <i>11/2/56</i>	
24b. REGISTRAR'S SIGNATURE <i>John Howard</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DATA

HOSPITAL

DISCHARGE

BUREAU V. S.

NOV 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11273

11277 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH Hollis	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 17, 1901	9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Dorchester C., Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Hollis		14. MOTHER'S MAIDEN NAME Mary Elizabeth Johnson		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Ada Hollis, RFD #2 Cambridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver DUE TO 156.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from July 10, 1956 , to November 16, 1956 , that I last saw the deceased alive on November 16, 1956 , and that death occurred at M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md.		DATE SIGNED 11-17-56					
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22b. DATE THEREOF 11/18/1956		22c. NAME OF CEMETERY OR CREMATORIUM Aireys Cemetery		22d. LOCATION (City, town, or county) Dorchester Co., Maryland		(State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		24a. REC'D BY REGISTRAR 11/19/56		24b. REGISTRAR'S SIGNATURE <i>John Macay Jr.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. Bellair Jr.</i>		ADDRESS Cambridge, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF NEALED - SAVING - 18

CERTIFICATE OF DEATH

REAU V.

AY 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11274

11278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS Hambrooks Blvd.	
3. NAME OF DECEASED (Type or print) Reba		First	Middle
		Last	4. DATE OF DEATH Nov. 22, 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 2, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Wilmington, Del	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Alexander Fleming	
14. MOTHER'S MAIDEN NAME Sallie Joseph		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Walter B. Johnson, Jr., Hambrooks Blvd., Cambridge	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Congestive heart failure Hypertension - arterio sclerosis CVD Cerebral thrombosis & L. hemiplegia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 22, 1956, to Nov. 22, 1956, that I last saw the deceased alive on Nov. 22, 1956, and that death occurred at 11:55 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE James U. Thompson M.D. Cambridge, Md. ADDRESS (Street, city or town, state) DATE SIGNED Nov. 23, 1956 PHYSICIAN'S NAME (Type) James U. Thompson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25, 1956	
22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Katherine R. Thomas.		24a. REC'D BY REGISTRAR DATE 11/24/56	
		24b. REGISTRAR'S SIGNATURE John MacL.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Montana State Health
Division of Health
Montana State Hospital
Missoula, Montana
Received from Dr. C. H. Johnson
on April 25, 1956.

BUREAU V. S.

April 25, 1956

Montana State Hospital (Montana State Hospital)
Montana State Hospital

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11275

Reg. Dist. No.

11279 CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 35 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS Slacum Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Handy	Middle Joseph	Last Major	4. DATE OF DEATH	Month Nov.	Day 9,	Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 8, 1915	9. AGE (In years lost birthday) 41 yrs.	IF UNDER 1 YEAR Months -----	IF UNDER 24 HRS. Days -----	Hours -----	Min. -----
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Accomac, Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Major		14. MOTHER'S MAIDEN NAME Nettie Boston		Address -----				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-9533		17. INFORMANT Rosie Cornish, Cambridge, Md.		INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion DUE TO 521X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lung Abscess						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Hour o. g. p. m.	Month 19	Day -----	Year -----	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----
21. I certify that I attended the deceased from April 21, 1956 to November 9, 1956 , that I last saw the deceased alive on November 9, 1956 , and that death occurred at 3 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Edwin Fassett</i> PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/1956		22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert W. Bellair Jr.</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR -----		24b. REGISTRAR'S SIGNATURE John Mace Jr.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION
CERTIFICATE OF DEATH

BUREAU U. S.

NOV 14 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11296

CERTIFICATE OF DEATH

11276

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 yrs. 12das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		d. STREET ADDRESS -		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Howard	Middle Harris	Last Melvin	4. DATE OF DEATH	Month November	Day 5	Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 28, 1885	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm worker		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Fletcher Melvin		14. MOTHER'S MAIDEN NAME Annie Harris						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT RECORDS: Eastern Shore State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 420.0		(b) Generalized Arteriosclerosis W. Heart Disease					several yrs.	
DUE TO (c) Psychosis W. Cerebral Arteriosclerosis							" "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Psychosis W. Cerebral Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. p. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) KENNEDYVILLE, MD.	(County)	(State)
21. I certify that I attended the deceased from alive on November 5, 1956,		10-23, 1954, to 11-5, 1956,		that I last saw the deceased and that death occurred at 7:45 AM, from the causes and on the date stated above.				
ACTUAL SIGNATURE Simon Virkutis.		ADDRESS (Street, city or town, state) M.D. E.S.S. Hospital, Cambridge, Md.		DATE SIGNED 11-5-56				
PHYSICIAN'S NAME (Type) Dr. Simon Virkutis								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-7-56	22c. NAME OF CEMETERY OR CREMATORIUM KENNEDYVILLE CEMT	22d. LOCATION (City, town, or county) KENNEDYVILLE, MD.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS STILL POND, MD.	24a. REC'D BY REGISTRAR DATE Nov. 6 1956	24b. REGISTRAR'S SIGNATURE S. Kennedy, Jr. John Mace, Jr.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
ROBERT LEE DAVIS	25	M	SHOT TO DEATH
ADDRESS	STREET	CITY	STATE
1000 1/2 10th Street	10th Street	SACRAMENTO	CA
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF HOSPITAL		
DR. ROBERT W. COOPER	HOSPITAL		
RELATIONSHIP TO DECEASED	RELATIONSHIP TO DECEASED	RELATIONSHIP TO DECEASED	RELATIONSHIP TO DECEASED
SON	SON	SON	SON
DATE OF DEATH	TIME OF DEATH	DEATH CERTIFIED BY	DEATH CERTIFIED BY
10-10-68	12:00 P.M.	DR. ROBERT W. COOPER	DR. ROBERT W. COOPER
CERTIFICATE OF DEATH			
I, ROBERT W. COOPER, M.D., certify that I am a licensed physician and surgeon in the State of California, and that the above information is true to the best of my knowledge and belief.			
SACRAMENTO, CALIFORNIA			
10-10-68			

BUREAU V.I.

9961 6 10. 11-5-55 - G. J. McMurtry

REVIEWED

11-5-55 - REVIEWED BY VERNON DUNN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12421

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek Md.		b. COUNTY Dorchester Co.	
c. LENGTH OF STAY IN lb 17 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Hospital		d. STREET ADDRESS Church Creek Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle Metcalf	Last Dee
4. DATE OF DEATH	Month Nov.	Day 30	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1935
9. AGE (in years last birthday) 21 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Saw Mill	11. BIRTHPLACE (State or foreign country) Bell Co. Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Bill Metcalf		14. MOTHER'S MAIDEN NAME Lula Saylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not Known	17. INFORMANT Bill Metcalf
		Address Church Creek	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Intracranial injury DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple fractures of skull DUE TO			
(c)			
INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Nov. 30 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Hi highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Church Creek Dor. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John Mac Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mac Jr.		DATE SIGNED 12/2/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 3, 1956	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Old Trinity Church Cambridge Md.	22d. LOCATION (City, town, or county) (State) Church Creek Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR 12/3/56	
		24b. REGISTRAR'S SIGNATURE John Mac Jr.	

BUREAU V. S.

DEC 10 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11281

CERTIFICATE OF DEATH

11277

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>	c. LENGTH OF STAY IN 1b <i>3 days</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookview</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cambridge Md.</i>		d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>Albert</i>	Last <i>Murphy</i>		
4. DATE OF DEATH	Month <i>11</i>	Day <i>6</i>	Year <i>1956</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/15/1870</i>		
9. AGE (In years less birthday) <i>86 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	11. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
13. CITIZEN OF WHAT COUNTRY? <i>A.S.H.</i>	14. MOTHER'S MAIDEN NAME <i>Mary Paul</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. _____-_____-_____- <i>442X</i>	17. INFORMANT <i>Mrs. Annie Collier, Brookview</i>	Address _____ <i>Brookview</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Asthma</i> DUE TO <i>442X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Right side cardiac heart failure</i> DUE TO <i>vascular renal disease</i> (c) <i>Arteriosclerotic cardio vascular hypertensive</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) ---					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>--</i> 19 p. m. <i>--</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ ---	20f. (City or town) _____ ---	(County) _____ ---	(State) _____ ---
21. I certify that I attended the deceased from <i>November 4, 1956</i> , to <i>November 6, 1956</i> , that I last saw the deceased alive on <i>November 6, 1956</i> , and that death occurred at <i>2:57 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>15 Locust Street, Cambridge, Md. 11-2-56</i> DATE SIGNED <i>Edridge H. Wolff</i>					
ACTUAL SIGNATURE <i>Edridge H. Wolff</i>	PHYSICIAN'S NAME (Type) <i>Edridge H. Wolff, M.D.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/8/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Brookview</i>	22d. LOCATION (City, town or county) <i>Brookview, Md.</i>	(State) _____ ---	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank J. Mallonby, E. H. Wolff</i>	ADDRESS _____ <i>11/8/56</i>	24a. REC'D BY REGISTRAR DATE <i>John Mac Jr.</i>	24b. REGISTRAR'S SIGNATURE _____ <i>John Mac Jr.</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE DEPARTMENT OF HEALTH—GAZIOMBRA

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11278

11282 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge R.D. 3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Shade	Middle Seward	Last Seward	4. DATE OF DEATH Nov. 18, 1956	Month Nov.	Day 18	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 19, 1871	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer self employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge R.D. 3		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Charles H. Seward		14. MOTHER'S MAIDEN NAME Mary Applegarth						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Val Seward, Cambridge, Md. R.D. 3		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 4 days		
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO						
{ DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cambridge	(County)	(State)		
21. I certify that I attended the deceased from 11/15/17 , 19, to 11/18/56 , 19, that I last saw the deceased alive on 11/16/56 , 19, and that death occurred at 9:45 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 136 Raw St. Cambridge, Md.		
ACTUAL SIGNATURE Lawrence Maryanov	PHYSICIAN'S NAME (Type) Lawrence Maryanov, M.D.	DATE SIGNED						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 20, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery	22d. LOCATION (City, town, or county) Cambridge, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth K. Thomas		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR John Mace Jr.	24b. REGISTRAR'S SIGNATURE John Mace Jr.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. C.

NOV 25 1956

RECEIVED

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

V.S. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18								11279							
11283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH								Reg. Dist. No.							
Item 1 Film G208 12-17-56 et															
1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				b. COUNTY Dorchester											
c. LENGTH OF STAY IN 1b 25 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13 Muir Street				d. STREET ADDRESS 13 Muir Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Sarah		First Dean		Middle Smith		4. DATE OF DEATH November 10, 1956		Month	Day	Year					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 15, 1880		9. AGE (in years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) James Island, Dor. Co.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John W. Dean								14. MOTHER'S MAIDEN NAME Mary Jane Meekins							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Solomon Dean, Taylors Island, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary occlusion								?							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)															
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <i>John Mace Jr.</i>								M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
								DATE SIGNED 11/6/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 7, 1956				22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery				22d. LOCATION (City, town, or county) Cambridge, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth P. Shouse</i>								ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR DATE 11/6/56		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

BUREAU V. S.

NOV 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11284

CERTIFICATE OF DEATH

11280

Reg. Dist. No. 11280

1. PLACE OF DEATH a. COUNTY Dorchester			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 20 years.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital			d. STREET ADDRESS 400 Willis St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Alonzo	Middle Refus	Last Swaninger	4. DATE OF DEATH Nov. 11, 1956	Month Nov.	Day 11	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1906	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 9	Hours 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No occupation, physically disabled			10b. KIND OF BUSINESS OR INDUSTRY Federalsburg, R.D.		11. BIRTHPLACE (State or foreign country) U.S.			
13. FATHER'S NAME since child Unknown			14. MOTHER'S MAIDEN NAME Unknown			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Albert H. Bell, 400 Willis St., Camb.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION ESSENTIAL DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 Hours		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Residual Poliomylitis - Kyphosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No						
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 Locust St	20f. (City or town) Cambridge, Md.	(County) Calvert Co.		(State) Md.		
21. I certify that I attended the deceased from 11/10/1956 to 11/11/1956 , that I last saw the deceased alive on 11/11/1956 , and that death occurred at 3:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Locust St Cambridge, Md.								
ACTUAL SIGNATURE <i>W.H. Hanks</i>	DATE SIGNED 11/12/56							
PHYSICIAN'S NAME (Type) W.H. Hanks								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 13, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery	22d. LOCATION (City, town, or county) Cambridge, Md.	(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Levett R. Thomas</i>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR John MacLean Jr.	24b. REGISTRAR'S SIGNATURE <i>John MacLean Jr.</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S

NOV 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11281

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First DORSEY	Middle BURKE	Last THOMPSON	4. DATE OF DEATH	Month Nov. 23	Day 1956	Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/30/77	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Alexander Thompson		14. MOTHER'S MAIDEN NAME unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. none		17. INFORMANT Eastern Shore State Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the rectum DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychosis with cerebral arteriosclerosis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stevensville Md.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Dec. 15, 1952 , to Nov. 23, 1956 , that I last saw the deceased alive on Nov. 23, 1956 , and that death occurred at 8:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Stevensville Md. DATE SIGNED 11/23/56								
ACTUAL SIGNATURE Thomas J. Dredge		M.D. E.S.S. Hospital, Cambridge, Md.						
PHYSICIAN'S NAME (Type) Thomas J. Dredge								
22a. BURIAL/CREMATION, REMOVAL (Specify) 11/26/56		22b. DATE THEREOF 11/26/56		22c. NAME OF CEMETERY OR CREMATORIAL Stevensville Md.		22d. LOCATION (City, town, or county) Stevensville Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar T Lane church Hill		ADDRESS church Hill		24a. REC'D BY REGISTRAR John MacL		24b. REGISTRAR'S SIGNATURE John MacL		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

BUREAU V.

NOV 27 1956

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11298 CERTIFICATE OF DEATH

11282

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 yr. 8 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 315 E. William St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence Morris	First	Middle	Last	4. DATE OF DEATH November 28 1956	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 6, 1862	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard Morris		14. MOTHER'S MAIDEN NAME Sally Ann Richardson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Dollie Purnell (Daughter)		Address 315 William St., Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH Sev. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Psychosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	20f. (City or town) -	(County)	(State)
21. I certify that I attended the deceased from March 22, 1955 , to Nov. 28, 1956 , that I last saw the deceased alive on Nov. 28, 1956 , and that death occurred at 4:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED Simon Virkutis							
ACTUAL SIGNATURE Simon Virkutis		M.D.					
PHYSICIAN'S NAME (Type) Simon Virkutis		Eastern Shore State Hospital, Cambridge, Md.					
22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Burial Nov. 30, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Hanover Co.		22d. LOCATION (City, town, or county) Salisbury, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Simon Holloway & Co.		ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR 11/29/56		24b. REGISTRAR'S SIGNATURE John Maca Jr.	
VS A15 (4) 15M 9/55							

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

TELETYPE NUMBER

TELETYPE ADDRESS

TELETYPE CITY

TELETYPE STATE

TELETYPE ZIP CODE

TELETYPE PHONE NUMBER

TELETYPE TELETYPE NUMBER

TELETYPE TELETYPE ADDRESS

TELETYPE TELETYPE CITY

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BUREAU V.

DEC 3 1956

RECEIVED

FBI - NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11285

CERTIFICATE OF DEATH

11283
11286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Darke</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i>		b. COUNTY <i>Wentzville</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13. <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>7 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>Snow Hill</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Elm Burnie Convalescent Home</i>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First <i>Frank</i>	Middle <i>W.</i>	Last <i>Trustt</i>	4. DATE OF DEATH <i>Nov. 20</i>	Month <i>Nov.</i>	Day <i>20</i>	Year <i>1956</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Aug. 12-1888</i>	9. AGE (In years last birthday) <i>67 yrs.</i>	IF UNDER 1 YEAR Months <i>6</i>	IF UNDER 24 MRS. Days <i>3</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>Petrol Bank Cashier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bank of Ocean City Md</i>		11. BIRTHPLACE (State or foreign country) <i>Gardiner, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>Snow Hill, Md</i>			
13. FATHER'S NAME <i>George W. Trustt</i>		14. MOTHER'S MAIDEN NAME <i>Hertula Purnell</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>412-03-4323</i>		17. INFORMANT <i>Mr. Leall Trustt, Snow Hill, Md</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <i>Cerebral Hemorrhage.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>					
DUE TO (c) <i>Cerebral Arteriosclerosis</i>				1 yr.					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>11/19/56</i>		20f. (City or town) <i>11/20/56</i>		(County) <i>11/20/56</i>	(State) <i>11/20/56</i>
21. I certify that I attended the deceased from alive on <i>11/19/56</i> , 19, to <i>11/20/56</i> , 19, and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>136 Race St.</i>	DATE SIGNED <i>11/20/56</i>
ACTUAL SIGNATURE <i>Lawrence Maryanov</i>									
PHYSICIAN'S NAME (Type) <i>Lawrence Maryanov</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Methodist</i>		22d. LOCATION (City, town, or county) <i>Snow Hill</i>		(State) <i>MD</i>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/23/56</i>		24a. REC'D BY REGISTRAR DATE 11-23-56		24b. REGISTRAR'S SIGNATURE <i>Dr. John Mac. Jr.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>May Dennis</i>		ADDRESS <i>Snow Hill, Md</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

NAME

SURVEAU V. S.
NOV. 23 1956
DECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11284

11285 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 2½ days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge—Maryland Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sallie	Middle Alice	Last Tuckett
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 18, 1880
9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Marine		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-8829	17. INFORMANT Mrs. Everett Thomas, Cambridge, Maryland Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary embolus		4 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) chronic nephritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ Oct 31, 1956, to Nov 3, 1956, that I last saw the deceased alive on Nov 2, 1956, and that death occurred at 4:45 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Alfred R. Maryanov M.D. ADDRESS (Street, city or town, state) 136 Race St., Cambridge, Md. DATE SIGNED 11/5/56			
PHYSICIAN'S NAME (Type) Alfred R. Maryanov, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 5, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Vienna Cemetery	22d. LOCATION (City, town, or county) Vienna, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE 11/8/56
			24b. REGISTRAR'S SIGNATURE John Macke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

BUREAU V. S.

9951 47 103

RECEIVED
1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11285

11299 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 9 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro		d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ada		First	Middle	Last	4. DATE OF DEATH Urry	Month	Day	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1 1888	9. AGE (In years lost birthday) 68 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unk Elijah Taylor		14. MOTHER'S MAIDEN NAME Louise Kemp		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-1977			
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Cerebral Arteriosclerosis DUE TO		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Address Cambridge, Md.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3d , 19 56 , to Nov 20 , 19 56 , that I last saw the deceased alive on Nov 20 , 19 56 , and that death occurred at 6:05 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Thomas J. Dredge M.D. State Hospital Cambridge, Md. Nov 20 1956 PHYSICIAN'S NAME (Type) Thomas J. Dredge		ADDRESS Greensboro, Md.		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/56		22c. NAME OF CEMETERY OR CREMATORIAL Greensboro		22d. LOCATION (City, town, or county) Greensboro, Md.		(State)	
23. FUNERAL-DIRECTOR'S SIGNATURE J. E. Boulaire		ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR DATE 11/23/56		24b. REGISTRAR'S SIGNATURE Jahn Maugh			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9561 92 NOV

REGELY ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 11280		
11287 Item 9 Film G207 11-29-56 et CERTIFICATE OF DEATH												
1. PLACE OF DEATH o. COUNTY Dorchester Co.					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.					b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.					c. LENGTH OF STAY IN 1b 2 Days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md.					d. STREET ADDRESS Vienna Md.					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lillie Elizabeth Adkins Willey					First	Middle	Last	4. DATE OF DEATH Nov. 19 1956	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 5, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR 159 months	IF UNDER 24 HRS. 69 days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife					10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Samuel Adkins					14. MOTHER'S MAIDEN NAME Mary Langfitt					Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None	17. INFORMANT W. Scott Willey Vienna Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 21 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. n. 19 p. m.					20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 105 CHURCH ST CAMBRIDGE MD.	20f. (City or town) Vienna Md.	(County)	(State)			
21. I certify that I attended the deceased from 18 NOV 1956 , to 19 NOV 1956 , that I last saw the deceased alive on 18 NOV 1956 , and that death occurred at 5 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE WALTER E. GUNBY JR. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR. DATE SIGNED 10 NOV 1956												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	22d. LOCATION (City, town, or county) Cambridge Md.					(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service Cambridge Md.					24a. REC'D BY REGISTRAR 11/23/56					24b. REGISTRAR'S SIGNATURE John Mac Jr.		

WYOMING STATE DEPARTMENT OF HEALTH - SHERIFF'S

CERTIFICATE OF DEATH

BUREAU V.

NOV 26 1956

KENGELEY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11287

11288 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 55 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital	d. STREET ADDRESS 218 Rambler Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Gorman Last Willey	4. DATE OF DEATH Month Nov. 10, 1958 Day Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1894
9. AGE (In years lost at deathday) yrs. 82	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Packing Co. Employed	11. BIRTHPLACE (State or foreign country) Lakesville, Md.
		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William E. Willey		14. MOTHER'S MAIDEN NAME Annie E. Wroten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		16. SOCIAL SECURITY NO. 1 217-10-8759	17. INFORMANT Elizabeth W. Willey, 218 Rambler Rd. Address Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH immediate	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary thrombosis 4 wks.	
		Myocardial infarction 5 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-7-56, 19, to 11-10-56, 19, that I last saw the deceased alive on 11-10-56, 19, and that death occurred at 11:10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Albert E. Bunker, M. D. ADDRESS (Street, city or town, state) M.D. 200 Maryland Ave., Cambridge, Md. DATE SIGNED 11-12-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov/12, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Katherine R. Horner		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE 11/12/56
		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

NOV. 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11289

11288

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. LENGTH OF STAY IN 1b <i>Several hr.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hurlock</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Roland Henry Windsor</i>		First <i>Roland</i>	Middle <i>Henry</i>
4. DATE OF DEATH <i>11-23-56</i>		Month <i>Nov.</i>	Day <i>23</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Widowed</i>
8. DATE OF BIRTH <i>1-5-1899</i>		9. AGE (In years from birthday) <i>57 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
11. BIRTHPLACE (State or foreign country) <i>Hurlock, Millin Co.</i>		12. IF UNDER 24 HRS. Days <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
14. MOTHER'S MAIDEN NAME <i>Blanche Harper</i>		Address <i>120 W. Hanover St., Baltimore</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>P. R. H. Windsor</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Washington</i>
20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i>	
		(State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED <i>11/23/56</i>	
EXAMINER'S NAME (Type) <i>John Mace Jr. M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-23-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Washington</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. McLaughlin, E. J. Market, Jr.</i>		24a. REC'D BY REGISTRAR DATE <i>11/23/56</i>	
		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

DEPARTMENT OF JUSTICE - FEDERAL BUREAU OF INVESTIGATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU U. S.

NOV 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12440

11290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md. Hosp		c. LENGTH OF STAY IN 1b 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
3. NAME OF DECEASED (Type or print) Albert		First G.	Middle . Young	Lost 17 Well St	4. DATE OF DEATH 11 6 1956	Month 11	Day 6	Year 1956	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1902		9. AGE (In years lost, birthday) yrs. 54	10. IF UNDER 1 YEAR Months 54	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert Young				14. MOTHER'S MAIDEN NAME Maude Rolley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-6900		17. INFORMANT Mrs. Martha Young		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic heart disease								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260 X Diabetes Mellitus								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Gangrene of Toe							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 227 Pine St-Cambridge, Md.	(County) M.D.	(State) Cambridge, Md.		
21. I certify that I attended the deceased from December 21, 1955 , to November 6, 1956 , that I last saw the deceased alive on November 6, 1956 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED J. Edwin Fassett									
ACTUAL SIGNATURE J. Edwin Fassett		PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/56	22c. NAME OF CEMETERY OR CREMATORIUM Bethel		22d. LOCATION (City, town, or county) Cambridge, Md.				(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Leon W. Henry (awards 1/16)		ADDRESS John Maugh		24a. REC'D BY REGISTRAR DATE 12/1/56		24b. REGISTRAR'S SIGNATURE John Maugh			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

NEVADA STATE DEPARTMENT OF NELLIS - ALTIMORE - 18

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
DECEMBER 12 1956				
BUREAU V. S.				
FBI - LAS VEGAS				
FEDERAL BUREAU OF INVESTIGATION				
U. S. DEPARTMENT OF JUSTICE				
18				